This program may need to be adapted to the local environment and infrastructure. This tool kit includes only the core components of the program for successful implementation. The work group that champions the peer-support breastfeeding program at an installation can identify areas where local adaptations may be necessary. The work group can also determine what adaptations will be implemented and how each adaptation will function within the program.

The Mom-2-Mom Program is not a breastfeeding education program; it is a peer support program designed to help new mothers over the initial challenges and anxieties associated with breastfeeding. Breastfeeding education is handled by installation subject matter experts such as lactation consultants, community health nurses, pediatricians, etc.

Mom-2-Mom
Peer Support Breastfeeding Program

Volunteer Resource Guide

The print, internet, and organizational resources referred to in this guide do not in any way constitute Department of Defense endorsement of the private entity, its website, or its products. Resources referred to in this guide are suggestions only.

PREFACE

The purpose of this guide is to supplement the Mom-2-Mom Breastfeeding Support Program volunteer training. The 7-hour training program is accomplished through a combination of lecture, discussion and role play, which not only gives the volunteers a chance to practice but allows the program coordinators to evaluate each volunteer's strengths and weaknesses.

The Mom-2-Mom Program is not a breastfeeding education program; it is a peer support program designed to help new mothers over the initial challenges and anxieties associated with breastfeeding. Breastfeeding education is handled by installation subject matter experts such as lactation consultants, community health nurses, pediatricians, etc.

This volunteer guide should not be used as a substitute for education by trained experts.

This volunteer guide has been reviewed by and received concurrence in 2005 from the following Consultants to the Surgeon General of the Army: Women's Health Issues; Obstetrics/Gynecology; Neonatology; Family Practice Nursing; and Pediatric Nursing.

Mom-2-Mom Program

Volunteer Resource Guide

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Mom-2-Mom Volunteer
One-Day Training Schedule
(Insert Date Here)

0830 Sign-in
0900 Introductions/Ice breakers
0920 Volunteer Notebook and Resources
0930 Breast is Best
0945 Basic Anatomy, Physiology (mother and baby), Transition, and Normal Patterns to the Initiation of Lactation
1015 Position, Latch, and Suck: Evaluating Good and Bad
1045 Break

1100 Giving Effective Help
1130 Liability/Documentation
1145 Support from Other Sources and Volunteer Notebook
1145 Explanation of the role-playing for the afternoon session

1200 Lunch

1300 Dividing into teams; reading assignments
1330 Scenario 1: Sore nipples/sore breasts
1350 Scenario 2: Not getting enough
1410 Scenario 3: Breast pain/tenderness +/- fullness
1430 Break

1445 Scenario 4: Sore mouth/sore breast/baby causing sore breast
1505 Scenario 5: sleepy baby/yellow baby/fussy baby
1525 Scenario 6: return to work/advice to quit
1545 Catch-up time and quick scenarios
1610 Course evaluation and certificates
1630 Absolute end!

Mom-2-Mom Volunteer
Two-Day Training Schedule
(Insert Dates Here)

Day One

0900 Sign-in
0915 Introductions/Ice breakers
0935 Volunteer Notebook and Resources
0945 Breast is best
1015 Basic Anatomy, Physiology, Transition, and Normal Patterns to the Initiation of Lactation
1045 Position, Latch, and Suck: Evaluating Good and Bad
1115 Break

1130 Giving Effective Help
1145 Liability/Documentation
1155 Explanation of the role-playing for next training day
1200 Dismissal

Day Two

0800 Welcome Back
0815 Divide into teams and discuss assignments
0830 Scenario 1: Sore nipples/sore breasts
0850 Scenario 2: Not getting enough
0910 Scenario 3: Breast pain/tenderness +/- fullness
0930 Break

0945 Scenario 4: Sore mouth/sore breast/baby causing sore breast
1005 Scenario 5: sleepy baby/yellow baby/fussy baby
1025 Scenario 6: return to work/advice to quit
1045 Catch-up time and quick scenarios
1110 Course evaluation and certificates
1130 Absolute end!

Mom-2-Mom Program
Referral List

Mom-2-Mom Coordinator	Contact Name: Phone: Email:
Mom-2-Mom Physician Consultant	Contact Name: Phone: Email:
Mom-2-Mom Lactation Consultant	Contact Name: Phone: Email:
Department of Pediatrics	Phone: Emergency/After Hours:
Pediatric Clinic	Contact Name: Phone: Email:
New Parent Support Program	Contact Name: Phone:
Breastfeeding Class	Contact Name: Phone:
Pregnant/Postpartum Physical Training Program	Medical Expert: Phone: Instructor-Trainer: Phone:
La Leche Breastfeeding Support Group	Phone:
Women, Infants, and Children Program (WIC)	Phone:

Expectations of a Mom-2-Mom Volunteer

- Your role is to provide support and basic information to the new mother. Be careful not to present yourself as a medical authority.
- Phone your buddy within 24 hours of being matched. Give your phone number to your buddy; encourage her to call you.
- If your buddy has already delivered, call her again in 1-2 days, 1week, 2 weeks, and 1 month at a minimum – more if requested or required. Even if she says everything is going well – call back.
- If your buddy has not delivered, call back two to four weeks prior to delivery. Encourage your buddy to call you from the hospital prior to discharge. Mail or email any appropriate handouts, and encourage her to read a breastfeeding book prior to delivery (*Nursing Mother's Companion* by Kathleen Huggins is a good one).
- Contact the Mom-2-Mom program coordinator if you are unable to reach mother within 48-72 hours of match – we can troubleshoot bad phone numbers, etc.
- Complete consults and return via email, mail, or drop off at the designated when convenient.
- If you have *any* questions about the program or a situation with a new mother, contact the Mom-2-Mom Program Coordinator.
- If in doubt, refer to the appropriate medical professional (See *When to Refer to a Lactation Consultant* and *When to Refer to a Health Care Provider* in this guide for further information.)

Back To Basics: Position, Latch And Suck

I. POSITIONING

1. Mother's position:
    a. chair vs. bed
    b. sitting vs. lying down
2. Baby's position:
    a. cradle hold & cross-cradle hold
    b. football/clutch hold
    c. side lying
3. Other positions to fit situations

II. LATCH-ON

1. Breast support
    a. C-hold
    b. 'nipple sandwich'
2. Baby's mouth
    a. opening
    b. tongue placement
3. Pull-in
    a. baby's body position
    b. baby's chin/nose
    c. continued comfort/support
4. Signs of Good Latch-On
    a. baby's head not turned
    b. breast deep in mouth
    c. chin/nose positions
    d. tongue placement
5. Pulling off breast
    a. breaking suction
    b. switching sides - burping

III. SUCKLING

1. Signs of good suck
    a. quick suck — let down

b. suck-swallow pattern

b. ear “wiggle”

2. Assuring adequate intake

a. > 6 wet diapers and 2 bowel movements per day

b. Baby ends feeding session on own

c. Baby appears satisfied after feeding

d. Weight gain

e. Newborn nursing 8-12 times per day

IV. GENERAL PROBLEMS

1. Sore Nipples
2. Sleepy baby
3. Weak suck
4. Lazy nurser
5. Fussy baby
6. Engorgement
7. Nipple Confusion
8. Flat/Inverted Nipples

- V. WHEN TO REFER (Your instructor will provide more information on when to refer. See *When to Refer to a Lactation Consultant* and *When to Refer to a Health Care Provider* in this guide for further information.)

Ten Commandments For Good Listening

1. Stop talking - You cannot listen if you are talking.
2. Put the talker at ease - Help her feel that she is free to talk.
3. Show her that you want to listen - Look, sound and act interested. Listen to understand rather than to oppose.
4. Remove distractions - Don't doodle, tap, or shuffle papers.
5. Empathize with her - Try to put yourself in her place so that you can see her point of view.
6. Be patient - Allow plenty of time. Do not interrupt her.
7. Hold your temper - An angry person gets the wrong meaning from words.
8. Go easy on argument and criticism - This puts the new mother on the defensive. She may "clam up" or get angry -- either way she is not listening anymore. Don't argue. Even if you "win," you lose.
9. Ask questions - This encourages her and shows you are listening.
10. Stop talking - This is the first and last, because all other commandments depend on it.

A GENTLE HINT THAT YOU SHOULD LISTEN MORE THAN YOU TALK: YOU HAVE 2 EARS AND ONLY 1 TONGUE.

New Mothers Can Be:

- Exhausted
- Energized
- Insecure
- Vulnerable
- Afraid of the baby
- Afraid for the baby
- Afraid of failure
- Afraid of looking foolish
- Lonely
- Disappointed in birth
- Relieved
- Grieving
- Angry, bitter
- High, excited
- Passive, weak
- Open to suggestion
- Quiet
- Talkative
- Emotional
- Determined to be in charge; to show they can snap right back
- Thinking of the past, recalling good/bad experiences
- Dwelling on life and death issues
- Afraid to bother people
- Very different in their interpretation of baby's behavior
- Protective
- Overwhelmed

Your Job as a Mom-2-Mom Volunteer:

- Building confidence
- Nurturing the mother
- Being kind, considerate
- Listening, caring
- Giving approval, reassurance
- Providing practical help
- Reinforcing the mother's skills with each child
- Respecting
- Providing hands on assistance
- Teaching, informing
- Providing resources
- Building hope
- Encouraging mother
- Helping mother trust her instincts
- Advocating
- Being honest, developing realistic expectations
- Encouraging partners to encourage and support mother
- Empowering the mother to make her own decisions

4 Step Counseling Technique: L. 0. V. E.

1. **L**…….listen
2. **O**…….observe
3. **V**…….validate
4. **E**…….educate

Working With New Mothers
And Building Their Confidence

- Respect her as a mother and as a person
- Meet the mother where she is
- Believe she wants what is best for her baby
- Trust her to know what is best for herself, her baby, and her family
- Accept and support whatever a mother feels or says
- Be in tune with women's feelings in pregnancy and postpartum
- Be aware of changes in family roles and relationships
- Recognize the difference between ordinary stress and severe stress during the early weeks
- Give practical help as needed
- Recognize and reinforce what the mother is doing well
- Limit suggestions and new information to what is of immediate importance
- Support, reinforce and reassure the mother

Steps in helping the overwhelmed mother

1. Give emotional support first.
2. Next, give suggestions to help give immediate physical relief.
3. Then, work with the mother to understand the cause of the problems.
4. Finally, the mother will be able to take action.

Helpful Words	Unhelpful Words	
Practice	Why?	Fail, failure
What do you think about….?	Try	Success, succeed
How do you feel?	Must	Sufficient, insufficient
Will this work for you?	Should	Satisfied, unsatisfied
Have you considered?	Normal	Unhappy
	Problem	Crying too much

Pitfalls In Counseling

- Making the task seem hard
- Saying the word “problems” instead of “questions” or “concerns”
- Telling a mother she is doing something “wrong”
- Not accepting your own limitation
- Getting overly involved in a mother’s private life
- Stressing your own experience
- Making value judgments
- Interrupting
- Overwhelming mother with facts or suggestions
- Stalling or skirting the issue; be open and honest
- Being too solution-oriented
- Allowing too much time between calls/visits
- Contacting mother at inappropriate times
- Making call/visit too brief or too long
- Forgetting to follow up
- Not letting mother know when you will be available

Counseling Evaluations

Use the following questions to evaluate your peer support interaction:

- Did the mother relax and enjoy talking to me?
    - If not, what skills can I use next time?
- Did I gather enough information to understand the problem?
    - If not, what information do I need to gather?
- What did I learn by observing?
- What support did I give her?
    - In what other ways could I have supported the mother?
- What information did I give the mother?
    - Was it appropriate?
    - Did she understand it?
    - If not, what do I need to do at the next contact?
- Did the mother need immediate physical comfort measures?
    - What suggestions did I offer?
- Did I tell her what to do, or
    - Did I offer information and allow her to decide on her own plan?
- Did I take usable notes during the consultation?
    - How can I improve my note taking?
- What follow up did we arrange?
- Did the mother seem to feel satisfied with the contact?
- Did I feel satisfied with my role in helping the mother?
    - If not, what can I do to improve my satisfaction?

Telephone Counseling Tips

Remember:

- You can't see mother or baby.
- Always ask the baby's name and age.
- Get as many details as possible.
- When in doubt, refer to the appropriate health care professional.

Tips for Better Telephone Counseling:

- Give your name at the start of the call.
- Establish rapport. Give the mother the sense that you are glad to spend time with her.
- Take notes while talking.
- Speak clearly.
- Pitch your voice a little lower than normal. Over the phone, high pitch voices come across as squeaky.
- Work at projecting warmth. Interest and sincerity will come across in your tone of voice.
- Be a good listener. Do not do all the talking.
- Use attending sounds and words to let mother know you are listening. Over the phone, silences seem longer than when face-to-face.
- Be patient.
- Empathize with the mother.
- Watch your body language and smile – your voice will sound more pleasant.
- Prevent distractions.
- Decide what to do about interruptions.
- If she seems to need more than information or reassurance, set up a face-to-face meeting.
- Before ending the call, repeat any instructions given.
- Call the mother in a few days to see how things are going.
- If the mother is calling often and seems overly dependent, she may need a referral. (See *When to Refer to a Lactation Consultant* and *When to Refer to a Health Care Provider* in this guide for further information.)

When to Refer to a Lactation Consultant

- Mother is very anxious about breastfeeding.
- Mother has flat or inverted nipples and infant is having problems latching-on.
- Infant has difficulty breastfeeding:
    - Latch-on is not consistently effective
    - Swallowing is not consistently heard
    - Feedings consistently last over 1 hour
    - Infant seems hungry after most feedings
- Mother is experiencing unrelieved engorgement.
- Mother is experiencing no breast fullness by the 5th postpartum day (or does not feel milk has come in).
- Mother has severe nipple pain, cracked or blistered nipples, or nipple soreness has not improved by 7-10 days after birth.
- Infant has inadequate intake (fewer than 10-12 feedings), output (less than 6-8 wet diapers or less than 3 bowel movements per 24 hours), or stools have not turned yellow by end of day 4.
- Infant has inadequate weight gain (normal weight gain is 1 to 2 ounces per day) or has not regained birth weight by 2 weeks of age.
- Infant shows bottle preference or refuses the breast (cannot accomplish latch-on) i.e. nipple confusion.
- Actual or perceived low milk supply.
- Family requiring time-intensive support and assistance.

If in doubt, refer.

Lactation Consultant Contact Information:

Name:

Phone:

Email:

Location:

When to Refer to a Health Care Provider

Infant

- Signs/concern of infant illness:
  - Rectal temperature higher than 100.5°F or less than 96 °F (if less than 2 months).
  - Poor feeding (change from normal), irritability, lethargy, sleeping more than 18 – 20 hours per day.
  - Difficulty breathing or rapid breathing (greater than 60 per minute).
  - Dehydration (decreased wet diapers, dark/concentrated urine, or urine has a strong smell).
  - White patches to mouth (thrush).
  - Persistent vomiting.
- Baby is more yellow than when discharged.
- Poor weight gain/weight loss.
- Cannot or refuses to nurse (does not demand to be fed).
- Worrisome for signs of physical abuse and/or neglect.
- Any situation requiring attention of a health care provider.

Mother

- Fever higher than 101°F.
- Pathologic engorgement that remains unrelieved after following your instructions for 24 hours.
- Hard lump, red, hot streaks on breast, painful to touch that remains unrelieved after following your instructions for 24 hours.
- Sore nipples, bright red, shiny or scaly skin of areola, itchy or painful to touch, suggesting candidiasis/yeast.
- Nipple cracks or fissures that do not heal.
- Nipple or areola has any lesion that is oozing scaling, crusting, or that seems unusual.
- Indications of difficulty coping, or other indications that require medical attention.
- Medication questions.

If in doubt, refer.

Pediatric Clinic Contact Information:

Name:

Phone:

Email:

Location:

Adapted with permission from “Intensive Course in Breastfeeding — Phase II” — Texas Department of Health

Choosing a Breast Pump

Selecting the best pump is based on your personal needs. Decide when and where you will use it. Do you need to carry it back and forth from work every day? Do you have a place to plug it in? What can you spend for a pump? Is renting a better option? Other options to consider when getting a breast pump:

- Portability
- Durability
- Noise level
- Ease of use – comfortable fit, should not hurt nipples
- Effectiveness –it should drain your breast almost as well as your baby.
- Ease of cleaning

Qualities to look for in a pump are:

- Amount of pressure put on the breast
- Suction control
- Funnel size and shape
- Amount of milk that can be stored
- Protection of the backflow into the pump from the storage bottle

General Pump Information. For more specific guidance, talk to a lactation consultant

Types	Qualities	Purpose	Cost (2003 estimates)	Functions/comments
Manual (hand-operated) pumps	- Small, easy to operate and carry. - Cylinder/piston /syringe type pumps have 2 glass or plastic cylinders.	- Pump on occasional basis, 1-2 times per week. - Allows the user to pump one breast while the baby is nursing on the other breast so extra milk can be stored for future use.	$14-$50	- Some manual pumps are more effective than others and are made for frequent use. - Use of these pumps is more flexible because no electricity is required.
Small electric pumps	- Portable. - Uses batteries or AC adapters to supply the power to motor. - Has a continuous suction cycle.	- Pump on occasional basis, 1-2 times per week. - Allows the user to pump one breast while the baby is nursing on the other breast so extra milk can be stored for future use.	$30-$150	- Some cheaper electric models are not effective and may cause pain or decreased milk production.
Full-size, semi-automatic electric pumps	- Pumps large volumes of milk in a short period of time. - Has a suck-release cycle that is closer to the pattern of a baby. - Efficient, quiet, not as portable.	- For a single user.	$200.00 - $250.00	- Should not be borrowed or shared because of the risk of contamination. - Usually rented. - Parts that attach the breast to the pump must be purchased.
Automatic self-cycling electric pumps	- Pump both breasts at the same time. - Quiet to operate. - Has carrying case / milk collection containers, battery pack.	- Used to pump milk regularly. - For a single user.	Expensive, prices start at $250	- Can be rented.
The hospital-grade rental pumps	- Has a suck-release cycle that is closer to the pattern of a baby.	-To increase milk supply. -Provides stimulation for the mother's breasts when baby is not nursing.		- Provides milk for a premature baby.

** Bicycle horn" "bulb"-style pump is not recommended because it can damage breast tissue and is difficult to sterilize.

Tips for using a pump

1. Wash your hands and nails thoroughly. Massage and stroke your breasts to stimulate the flow of milk.

2. Moisten your breast before applying the breast flange for good suction.

3. Look at a picture of your baby or listen to relaxing music.

4. Ask friends whether or not they needed a pump and what kind they used. Ask what pump features they found helpful and what could have been better.

5. Call your peer-support buddy for advice.

6. Contact the local La Leche League for information.

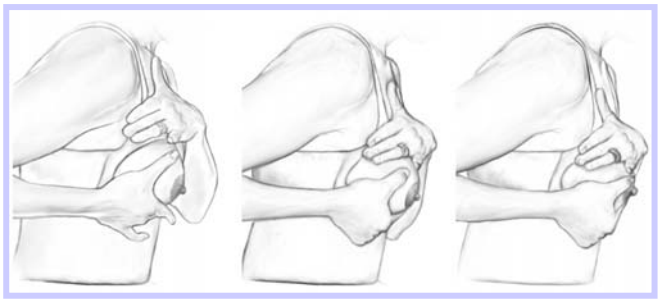
7. Be creative in finding places to pump.
    a. Use an office with an electrical outlet, bathroom with outlet, aircraft lavatories, breastfeeding/lactation room, unused locker room. A manual pump may be better if you are going to be pumping in places with no electricity, such as in a tent, out in the woods, in a truck, etc.
    b. Pump and air express breast milk home on a plane if traveling extensively. A meat packing company or ice cream store (like *Baskin Robbins*) are good places to get dry ice.
    c. Put up a "Mother's Room in Use" sign on the door to let others know that you are on a 15 minute pumping break.
    d. Put pumping sessions on your work calendar (labeled as "no meetings"), to try to avoid having schedule conflicts.

Steps for Hand Expression of Breast milk

Hand expressing milk from your breasts is a good skill to learn even if you plan to buy a pump. Expressing milk by hand can be used if your pump is temporarily unavailable or breaks. Even if you don't plan to pump, hand expressing milk can help keep improve your milk supply or provide an occasional bottle so someone other than you can feed the baby. Hand expressing milk costs nothing but it does take time and practice. Your first tries may feel awkward.

Before you start expressing:

- Each time you express milk, use a clean container.
- Wash your hands and nails.
- Massage and stroke your breasts to stimulate the flow of milk.
- Relax and think about your baby.
- Look at a picture of your baby.



Specific steps:

1. Place a wide mouth cup or jar or other container under your breast to collect the milk.
2. Hold your breast by placing your thumb about an inch above the areola and first two fingers under your breast.
3. Roll your nipple between your thumb and fingers to cause "let-down" (tingling sensation with a strong surge of milk).
4. Press your thumbs and fingers together, rub backward toward your chest. Gently roll forward on your breast pressing the milk out into the cup.
5. Roll and press on your breast at different areas until no more milk flows out.
6. Do not press or squeeze your nipple.
7. You will need to express each breast several times to get the desired amount of milk or when your breasts are soft.
8. Empty your breasts on a routine schedule to help maintain your supply.

Note: All drawings in this manual were obtained from USACHPPM Pregnancy and Postpartum Physical Training Program materials.

Breastfeeding Challenges

Engorgement
Engorgement occurs when your breasts are full of milk. Your breasts will feel swollen, hard, and painful.

To ease/treat engorgement:

- Pump your breasts or hand express a little of your milk.
- Use warm, wet towels to relieve fullness.
- Do gentle breast massages. Stroke your breast from the outer edges downward to the nipple area with your palm during a warm shower.
- Pour or slosh warm water over your breasts. Lean over a bowl of warm water
- Use ice packs for a short time between feedings to reduce swelling.
- Cover sore breast with chilled green cabbage leaves and change every 2 hours.
- Do not skip feedings.
- Start feedings on the least sore side.

If you are so engorged that you cannot obtain a latch or let-down, try Reverse Pressure Softening (RPS).

1. Place a finger on top and bottom of the nipple base and press towards the chest.
2. Hold fingers there for a minute then, still applying pressure, gently spread fingers ½ inch to 1 inch away from the nipple.
3. Repeat on sides of the nipple base. This action moves enough swelling away from the nipple that some milk can be expressed.
4. Repeat until breasts actively begin to leak.
5. Manually massage or pump to decrease engorgement.

Plugged duct
A plugged duct is a tender, small lump in the breast where the milk has collected. A plugged duct can lead to a painful breast infection called mastitis. Plugged ducts occur more frequently when:

- A feeding is delayed or missed
- If your baby isn't feeding well
- Improper positioning of the baby at your breast
- Supplementary bottles
- Overuse of pacifiers
- Dried milk secretions on the nipple
- Wearing tight bras, underwire bras or other tight clothing

To ease/treat a plugged duct:

- Put warm, moist towel on the breast that has the plugged duct before a feeding.
- Clean your nipples after every feeding to make sure that no dried milk is blocking the ducts.
- Breastfeed first on the breast with the plugged duct.
- Let baby nurse more often for longer periods of time.
- Massage the plugged area while your baby is nursing. If this is too painful, the back of an electric toothbrush or the handle of an electric razor can provide a gentle vibratory massage than can help reduce the plug.
- Wear a supportive (nursing) bra that is not so tight that it puts pressure on milk ducts.
- Avoid wearing an under-wire bra.

- Change breastfeeding positions often to put pressure on different ducts. Changing the baby's position so that the chin or nose is adjacent to the lump is most effective.
- Do not stop or slow down on feedings.
- Get plenty of rest.

Overactive milk ejection reflex

The milk ejection reflex or "let-down" is a tingling sensation followed by a strong, heavy rush of milk from your breasts. A baby's cry or just thinking about your baby may cause this "let-down" reaction and your breasts will leak milk.

What to do about "let-down" between feedings:

- Wear disposable nursing pads and/or reusable, washable cotton pads in your bra to catch milk leakage. Change these frequently to keep nipples dry.
- Reduce leaking by not missing feedings or going longer between feedings than usual.
- To stop the "let-down" reflex, cross your arms across your chest and apply slight, gentle pressure.
- If gentle pressure doesn't stop the leaking, express some milk by hand.

Storing Breast Milk

Storing milk at home and/or work

- Always wash your hands before handling your milk.
- Be sure to use only clean containers to store expressed milk. Try to use screw cap bottles, hard plastic cups with tight caps or special heavy nursery bags that can be used to feed your baby.
- Do not use ordinary plastic storage bags or formula bottle bags for storing expressed milk.
- Put the date and time on each container when you store it.
- Buy and use a thermometer to make sure your milk storage area is at the right temperature.
- Breast milk can stay safely at room temperature (77^{o} F) for 4 hours.
- Freshly expressed breast milk can be stored in the refrigerator for 48 hours at 39^{o} F.
- If refrigeration is not available, you can safely store breast milk in a cooler with ice packs (at 59^{o} F) for up to 24 hours.
- Use sealed and chilled milk within 24 hours if possible. Throw away all milk that has been refrigerated more than 48 hours.
- Always refrigerate newly pumped milk before mixing it with previously pumped refrigerated or frozen breast milk.
- Freeze milk if you will not be using it within 24 hours.
- Throw away milk that your baby doesn't finish. Do not save it. Germs grow quickly in warm milk.

Freezing milk at home

Breast milk can be frozen safely. Buy a thermometer to ensure the freezer is at the appropriate temperature. Frozen breast milk should be stored at -20 to -70 ^{o} F. Use the following guidelines when storing frozen milk:

- Never refreeze thawed breast milk.
- Do not add fresh milk to already frozen milk in a storage container.
- Store milk at the back of the freezer. Never store in the door section.
- Make sure to label the milk with the date that you freeze it.
- Use the oldest milk first.
- Freeze 2 to 4 ounces of milk at a time, because that is the average amount of a single feeding.
- Leave about one inch space in the top of the container because the milk will expand when frozen.

Frozen milk may be stored safely for:

- 2 weeks in a freezer compartment inside the refrigerator (small, dorm-size refrigerators)
- 3 - 6 months in refrigerator freezers with a separate external door.
- 6 -12 months in a manual defrost deep freezer which maintains a temperature of -4^{o} F.
- No longer than 6 months in a self-defrosting freezer because these freezers have warming cycles.

Thawing Breast Milk at home

- To thaw breast milk,
    - Place it in a container in warm water or
    - Run under cool or lukewarm running tap water or
    - Place in the refrigerator overnight.

- Thawed milk should be kept in the refrigerator no longer than 24 hours.
- Gently swirl thawed milk to mix it. The fat in the milk rises to the top. (Avoid shaking the milk as this destroys some nutrients.)
- **Do not** heat milk in the microwave or on the stove.
    - Microwaves do not heat evenly.
    - Unevenly heated milk can burn or hurt your baby.
    - Bottles can explode if left in the microwave too long.
    - Excess heat can destroy important proteins and vitamins in the milk.
- Throw away milk that your baby doesn't finish. Do not save it. Germs grow quickly in warm milk.

Storing breast milk in the hospital

If the hospital has a pumping room, it should have breast milk storage bottles, labels, storage bins and a sink with soapy water to clean your pumping kit. Always wash your hands before pumping or handling your milk. Use as many bottles as you need but start with new containers each time that you pump. Do not add milk to previously collected milk even if there is room in the bottle because of risk for infection. Label each bottle with your baby's name and date and time pumped.

If there is no pumping room, ask your baby's nurse or lactation consultant to:

- Give you breast milk storage containers, labels, bottles.
- Show you the refrigerator or freezer for breast milk storage. Never store breast milk on the door of the freezer because the temperature changes and the breast milk can thaw.

Freezers for breast milk should be separated from other freezers at the hospital. Freezer should be labeled for specifically for <u>breast milk only</u>.

If you are pumping at home and will be bringing the milk to the hospital within 48 hours, refrigerate it within 1 hour after pumping. If you are unable to bring the milk to the hospital within 48 hours, freeze that milk. And if your baby is not allowed to eat, freeze all the milk that you pump.

To bring frozen milk to the hospital, pack it in a cooler. Breast milk should be stored in aseptic containers with air tight seals. Containers should be hard sided. If shipping milk, use dry ice. Regular ice melts, raises the temperature of the water and causes milk to thaw faster. For further information about transporting breast milk, ask your hospital's lactation specialist.

Common Breastfeeding Questions

How to increase your milk supply

- Be sure your baby is latched on and positioned correctly at the breast. Your baby's mouth should be placed on the areola (the darker skin area) behind the nipple.
- Breastfeed your baby frequently for longer periods of time.
- Breast milk supply is based on frequent and effective breast emptying. Have baby fully nurse the first breast. Offer the second only via infant feeding cues.
- "Switch nursing"-- switch back and forth between breasts two or three times during each feeding.
- Rest, relax, eat a nutritious diet and drink enough fluids.
- Don't let your baby sleep through feedings.
- Pump milk between feedings.

Is your baby getting enough to eat?

Signs that your baby is getting enough milk:

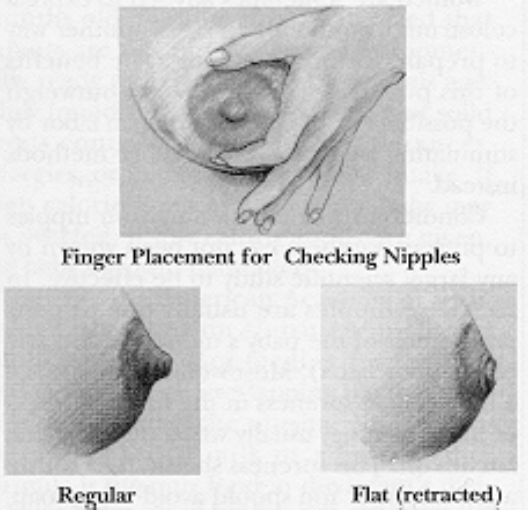
- Your baby nurses at least 8-12 feedings per 24-hour period.
- You can hear sounds of your baby swallowing and see sucking motions of the cheeks while breastfeeding.
- Your baby will be alert and active, appear healthy, have good color, firm skin, and will be growing in length and head circumference.
- Your baby has wet diapers: 6-8 wet cloth diapers or 5-6 disposable diapers per day.
- Your baby has at least 3-4 bowel movements every 24 hours for the first four weeks. (After four weeks, the number of bowel movements varies for each baby.)
- Weight gain -- Your baby should gain an average of at least 1 to 2 ounces per day after the fourth day of life.

Infant growth spurts

Infant growth spurts, also called appetite spurts, are a period of rapid growth where your baby will have a bigger appetite than usual. Your baby may want to nurse with an increased demand and frequency, be very fussy and cry more than usual. These growth spurts occur at 3 weeks, 6 weeks, 3 months and 6 months. During these periods, you should breastfeed on demand. After a few days, your milk supply will catch up with the increased demand.

Nipple Care

Inverted or flat nipples



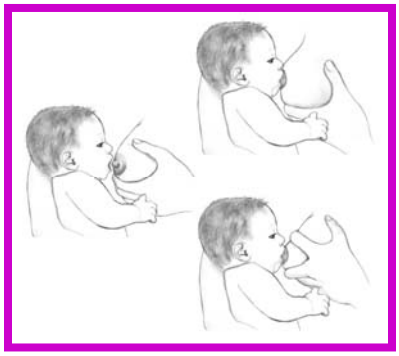
Breastfeeding can be done with any kind of nipple. Flat nipples do not stick out or become stiff when stimulated or cold. Inverted nipples draw in rather than stick out when the areola (the darker part of your breast) is compressed. A little preparation can help overcome challenges associated with flat or inverted nipples.

Before feeding:
Use a breast pump just before feeding your baby to help draw out flat or inverted nipples.

Sore Nipples

You must take care of your nipples during the time you are breastfeeding your baby. Poor nipple hygiene can lead to dry, cracked, bleeding nipples. It can be painful to breastfeed. Nipple soreness is a symptom you should not ignore. The most common causes of sore nipples are:

- Incorrect positioning at the breast
- Poor suction
- Improper latching
- Thrush (a fungal infection)



Although nipples are usually tender at the beginning of a feed, this should subside after the first minute or two. If you feel continued or increasing pain or soreness when your baby is nursing, your baby may be latching on incorrectly. To help your baby latch-on correctly:

- Use a breast pump just before feeding your baby to help get your baby to latch.
- Guide the nipple to your baby. Tilt the nipple toward the roof of baby's mouth to encourage better placement. In this way, the palate protects the nipple.
- Put in as much of the nipple and areola as possible into your baby's mouth.

- Do not let your baby slide on your nipple.
- Make sure your baby's mouth is wide open so that your nipple goes far back into the baby's mouth.
- Avoid prolonged pauses during feeding. During a pause, the nipple begins to retract to a non-nursing length.

Avoid pulling baby from the breast. To break the suction during a feeding, insert your finger into baby's mouth and slide along the gums.

Common treatments for sore nipples:

- Lean your breast into a basin with mildly hot water for at least ten minutes. The moisture helps heal the nipples and also relieves an engorged breast.
- Give short, frequent feedings to your baby.
- Put a few drops of breast milk on your nipples after each feeding and let dry before putting your bra back on.
- Soak a cracked, sore nipple in freshly expressed breast milk to heal and soothe.
- Use a "nipple cream" as prescribed by your health care provider.
- Change positions every few feedings.
- Bring baby to your breast, not your breast to baby.
- Learn proper positioning of your baby at your breast. Your baby's nose and chin should be touching your breast.
- Wash your nipples with warm water daily. Air dry and expose to sunlight. The Montgomery glands that surround the nipples ooze a liquid that lubricates the skin and inhibit growth of bacteria.
- Keep your nipples dry. Change breast pads when they get wet and empty breast shells often.

Thrush can infect both you and your baby. See your doctor or a pediatrician to get a medication that can be applied to your nipples and to your baby's mouth.

If you have sore nipples:

- Avoid using soap, alcohol, astringents or wet tea bags on your nipples. Acid in tea acts as an astringent. These items cause drying and cracking rather than healing.
- Avoid using a hair dryer or sun lamp to dry the skin.
- Avoid using home remedies like cooking oils or honey.

If you can't tolerate baby feeding on the breast with a sore nipple, feed your baby on the healthy breast until the sore nipple is healed. Express or pump milk from the affected breast every time that you would normally feed your baby to keep up milk production on that side and make an appointment to see a lactation consultant.

Mom-2-Mom Client Consult Report

Mom's Name:

Baby's Name:

Date of Consult:

Age of Baby:

Counselor:

Mom's Concerns:

☐ Sore Nipples	☐ Sleepy Baby	☐ Pumping
☐ Tender Breasts	☐ Refusing Breast	☐ Milk Storage
☐ Nipple Blisters/Sores/Cuts	☐ Frequent Nursing	☐ Return to Work
☐ Engorgement	☐ Overabundant Milk	☐ Weaning
☐ Adequate Intake	☐ Supplementing	☐ Sleep Issues
☐ Fussy Baby	☐ Starting Solids	☐ Fertility
Other Concerns:		☐ Medications

Summary:

Follow Up/Referral:

Scenario: Sore Nipples and Sore Breasts

Mother: Mary Shooter, 35 year old Active Duty Major, first child, husband TDY to Turkey
Child: Gatlin, 3 day old, term, uncomplicated, 1-4 hours between feeds, 2 stools, 6 urines
Interaction: discharged yesterday, first phone call

Concern #1: None: "I have the normal amount of pain all throughout the feed."

Elicited description: entire nipple is sore throughout the feed, but "I was told it was going to hurt, like running a marathon." Mom is normally a B-cup size, and is now C-cup. Baby is voracious, but satisfied with feed; Mom reports no engorgement, milk is "not yet in." States baby latches onto her nipple just like her friend's child latches onto a playtex nipple (areola is very visible). Mom denies flat/inverted nipples. A friend taught her the cigarette hold. Baby nurses in a variety of positions and seems content. No bottles used! No cracks, sores, lines.

Key points that should be determined

- Mom's description is useful: no cracks, sores
- Not likely to be engorgement, thrush, nipple preference
- Things to consider: short frenulum, tongue position, baby position, breaking suction
- Soreness is throughout feed and just at nipple
- Strong suck and suction breaking may be contributory
- Most likely issue is that baby is sucking on nipple only instead of getting entire areola into mouth

Keys to management

- Review proper latch (areola well in mouth, head position, breaking suction)
- Normal tenderness should last a few days, with a proper latch
- Nipple problems: review solutions
- Encouragement, support; follow-up no later than 3 days

Other nipple problems:

- Sore at beginning of feed, or after first day: latch, position
- Burning, itching: thrush
- Top of nipple sore: not deep enough, tongue high
- Bottom of nipple sore: too much lower breast, baby's lower lip may be tucked in
- Tip of nipple: also include short tongue
- Entire nipple: also vigorous suck, tongue curling, bad suction break. Mom leaning over
- Pain later in feed: change in position
- Engorgement may result in nipple suck, thus pain
- Nipple preference
- Check tongue: look for it on top of lower gum (retract baby's lip)
- Short tongue/frenulum may result in "smacking" while feeding
- Inverted/flat nipples may cause poor latch
- Baby biting/teething
- Less-than-optimal pumping
- Chapped nipples due to overly-vigorous cleaning
- Medical skin problems: rashes or dermatitis unrelated to breastfeeding
- Tight bra or rough seams
- Possible new pregnancy?! (74% of pregnant nurses have nipple pain)

Scenario: "Not Getting Enough"

Mother: Anne T. Biotecs , 19 year old Private, first child, husband TDY to Taszar, Hungary
Child: Annette, 2 day old, term, uncomplicated, 1-2 hours between feeds, 2 stools, 6 urines
Interaction: discharged yesterday, first phone call

Concern #1: "My baby is hungry; she wants to eat all the time; can I give some of the formula from the discharge pack?"

Elicited description: Discomfort with the beginning of the latch, but no pain or persistence. Baby looks to be latching well and nurses for 10-15 minutes comes off, then wants more immediately and nurses on other side for 10 minutes, then falls asleep. Poops during every other feed; urine too. Sleeps till next feed, which the baby wakes up for on her own. First sergeant came by and recommended supplemental feedings. Mom's milk is not "in."

Key points that should be determined

- This feeding pattern is very normal; demand feedings should be encouraged!
- Supplement interest may have been initiated externally (not Mom's idea)
- Child is vigorous and voiding appropriately
- Mom's rest and mental health need to be verified

Keys to management

- Mom should expect that long and frequent feeds will continue until the milk transitions; mom needs the support and reassurance that things are going WELL
- Reinforce that unrestricted feeding will have the following benefits:
  - Colostrum provision
  - Prevents painful breast engorgement
  - Will bring in Mom's milk more quickly
- Supplements may cause the following:
  - Nipple preference issues
  - Sensitivity to cow's milk proteins (allergy or intolerance)
  - Engorgement
  - Delayed milk transition (important to emphasize)

Other worries about the early days

- Weight loss (4-7% of birth weight is normal); should be back at birth weight by 2 week visit.
- Weight loss should stop once milk supply is plentiful
- Infant dehydration (symptoms: dry mouth, weak cry, listless, decreased urine output, dark or strong-smelling urine)
- Urine output: 1-2 wet diapers during first 2 days. If less than 3 wet diapers after first 2 days, send to doctor
- Pacifier use: can contribute to baby weight loss, latch problems, early weaning. Recommend NOT using pacifier if there are concerns about breastfeeding
- Is mom getting enough rest? Get help! Rest is essential.
- Harmful advice: "A little formula never hurts." or "Get some rest, Mom. I will give the baby a bottle."
- Does mom have post-partum depression? She needs emotional support.

Scenario: Breast Tenderness/Pain +/- Fullness

Mother: Truly Payne, 35 year old Active Duty Major, third child, husband works at auto parts store
Child: Frank, 4 day old, term, uncomplicated, 3-4 hours between feeds, 4 stools, 5 urines
Interaction: discharged early, second phone call

Concern #1: "My baby is screaming, he won't latch, and I'm gonna explode."

Elicited description: Mom reports milk "in." This is a "good" baby who sleeps long between feeds and sometimes even needs to be awakened, then nurses "well." This is different from her other two children who nursed actively during the first few days. The baby looks ready to nurse, but won't latch and nurse. Mom reports "fussy" while trying to latch. Breasts are enlarged; she changed two bra sizes during pregnancy and even her pregnancy bra feels tight now. Areola is hard "like the tip of her nose"; breasts are firm, warm, and shiny.

Key points that should be determined

- This is classic engorgement and needs to be addressed AS SOON AS POSSIBLE!
- Contributing factors include: longer time between feeds, age of child
- Inability to latch is due to engorged areola

Keys to management

- Apply warm, moist compress before feeding to stimulate let-down
- Massage from outside-in in circular motion to assist let-down
- Feed frequently, at least every 2 hours
- If breasts are not soft after a feed, pump or hand-express
- Cold compresses between feeds if necessary
- If latch is an issue, express/pump to soften the areola up, then nurse. If mom is concerned about this worsening the milk supply issue, tell her the point is to get the baby latched to EMPTY the breast.
- Prompt treatment will prevent:
  - Lack of Feed and weight loss issues
  - Sore nipples
  - Increased risk of mastitis
  - Breast cell damage

Other thoughts about tender breasts

- Plugged duct: No fever, one tender spot or lump. Pain is mild and gradual. Treat with warm compresses and massage, frequent feeds, loose clothing/bra.
- Mastitis: Sudden, localized, intense pain, flu-like feeling and temp >101. Cracks may be an issue. Refer to a doctor/nurse; manage as above and also with rest, good latch and good nursing.
- Abscess: Medical problem; usually due to untreated mastitis; fortunately rare.
- Lumps: If persist for more than a week, send to gynecologist / family practice.
- Blood in milk: Continue to nurse; if after 2 weeks of baby age, seek medical advice.
- Deep breast pain: Muscle strain, strong let-down, mastitis, engorgement, fibrocystic disease, breast injury……if persists, send to lactation consultant initially.

Scenario: Sore Mouth/Sore Breast/Baby Causing Sore Breast

Mother: Monica Albicanz, 25 year old Active Duty Staff Sergeant, first child, Dad also Active Duty
Child: Candy, 2 month old, term, uncomplicated, growing well, nurses well when Mom available, takes bottle well from caretakers
Interaction: Mom calls buddy for help

Concern #1: "Baby not nursing as well and left breast has new itchy-burning sensation."

Elicited description: Mom returned to work 2 weeks ago after a short convalescent leave. Mom pumps at work 3 times per day and nurses the baby before work, after work, and twice at night. Baby had check-up last week and was "just perfect" according to pediatrician. Baby takes pacifier and is bonded to just one; has never received formula. Mom started pumping and introducing expressed breast milk 2 weeks prior to return to work. Neither is taking any meds, except oral contraceptives (mini-pill for Mom). Baby's mouth always seems to have milk in it, along the roof. Mom's left breast has an itchy-burning nipple and new tenderness and new shooting pains after feeds. Baby has red area around genitalia; diaper rash ointment and corn starch not helping.

Key points that should be determined

These concerns are new, especially the breast concerns.
Baby is exposed to various plastics: bottles, pacifiers; Mom is pumping.
Baby probably has thrush (mouth yeast infection) and yeast diaper rash.
Mom probably has breast yeast infection.
No antibiotics in use.

Keys to management

Send both to the baby's health care provider.
Anticipate that baby will get put on nystatin (generic name) or gentian violet oral suspension and cream.
Mom should discuss her breast symptoms and probably will be put on nystatin cream.
Mom should get relief in 1-5 days, may get worse before she gets better.
Mom's breast may benefit from extra water cleansing.
Extra attention needs to be paid to thorough cleaning of everything that comes in contact with baby's mouth and mom's breasts, and keeping disposable items fresh, such as nursing pads.
If relapse occur, pay more attention to prevention strategy. Sometimes Mom is not treated and the yeast bounces back and forth.

Other soreness issues:

Biting/teething: Not a reason to wean, though many do. Ask lactation consultant for helpful things to do.
Blisters and sores: Cracked and open sores on the breast can get infected, so they need to be kept reasonably clean and dry. Herpes blisters need to be completely separated from the baby and from milk (bandage over blister). Only direct contact causes problems.
White blisters are due to duct obstructions.

Scenario: Sleepy Baby/Yellow Baby/Fussy Baby

Mother: Lisa Ruben, 22 year old Active Duty 2Lt, first child, single, Dad uninvolved.
Child: Billy, 5 day old, term, uncomplicated, feeds 5 times/day, Mom wakes for feeds, 3 stools, 1 urine in last day, sent home 4 days after C-section for "big baby-little Mom."
Interaction: first call, got back to apartment yesterday.

Concern#1: "Baby is sleeping more and looks more yellow."

Elicited description: Mom had C-section after 18 hours of labor throughout the night. She put the child to the breast in the delivery room and doesn't remember most of the next day due to her lack of sleep. During the next two days she found it difficult to move much and was happy that the nursing staff watched the baby a fair bit. On the last day she took more care of the baby and her breastfeeding experience is what she remembers her friend's to be like. The doctor who evaluated the baby prior to going home remarked that the infant was yellow, but not too yellow, and said something about the weight. The doctor told her to call if the baby got more yellow, but Mom doesn't know the phone number for that doctor. It is now 5 p.m. on the Friday before a 3-day weekend. Mom doesn't know if her milk is "in."

Key points that should be determined

Mom had a long, difficult labor, followed by a C-section and a difficult recovery. She probably didn't have a lot of great breastfeeding in the hospital; her milk is probably not transitioned since she has had limited exposure. In addition, the infant probably received supplementation by the nursing staff, which further contributed to the lack of breast stimulation.

Baby was noted to have jaundice and weight issues prior to discharge, and the jaundice now seems to be worse.

Mom doesn't seem to quite have it all together and help may not be as available due to the long weekend, which is just starting.

Feeding pattern is too few feeds, with too few voids; baby is TOO sleepy.

Case#2: same story but is fussy and wants to feed at least 12 times/day and is more yellow.

Additional descriptions: Mom is an A-cup and her breasts did not change size during pregnancy. She notes some colostrum, but nothing more. Baby wants to latch, starts to nurse, then quits and starts to cry.

Additional key points: Baby sounds hungry, but dissatisfied with current feeding management

Discussion

Sleepy yellow babies may be sleepy FROM the high bilirubin levels, so are not awake enough to eat enough to eliminate their bilirubin (jaundice).

The hungry baby is also jaundiced but is FRUSTRATED, apparently from not having milk. Rather than providing stimulation to the breast, this child has given up!

Mother and infant need an immediate medical evaluation from a clinic or even from the Emergency Room. Medical concerns are an elevated bilirubin level (can cause brain damage) and too much weight loss (dehydration and shock). These babies probably will be admitted to the hospital for phototherapy. Many doctors would choose to supplement with formula. With the assistance of a competent lactation specialist, a successful breastfeeding outcome MAY occur. Both of these mothers are drained; and the second mother may have inadequate breast tissue (although that is estimated at under 1% of women) or may have had breast reduction surgery.

Scenario: Return To Work/Advice To Quit

Mother: Priscilla Piper, 25 year old civilian fulltime secretary, second child; Dad is biology teacher.
Child: Peter, 10 week old, term, uncomplicated, doing everything right.
Interaction: no contact in weeks.

Concern #1: "I go back to work in two weeks; my husband says I better start weaning now."

Elicited description: "I quit nursing with my first one before returning to work 10 years ago. I am enjoying my nursing experience, but I just don't see how I can work and nurse my baby at the same time. The other secretary in my office tried to pump at work, in the restroom, but our boss then complained to others in the smoking shelter that she was wasting company time. I wish that I could stay at home more but our finances are getting tight and my mother will watch the baby. She seems excited although she tells me I should wean the baby now."

Key points that should be determined

What are mom's desires, motivation, and level of determination?
What options are available if she chose to continue to provide her own milk?
What are the motivations of others around her?
Has she pumped before? How did it go?

Discussion

This is a very difficult decision for any mother.
The baby is not always going to require as much nursing as he is right now: complementary foods can be introduced in 2-4 months if desired, and some breastfeeding is better than none.
Support may be better at work than for her friend, now that the boss has changed.
Pumping isn't the only answer; if the caregiver can travel with the baby, then the baby can be brought to the mother for feeds during breaks and meals. As the baby gets older, interest in nursing will mostly only occur when mom is around.
Formula is expensive! Even the formula company representatives estimate that giving a baby 30 ounces of formula a day costs $70 per month. Most estimates of formula costs are in the neighborhood of $800 for 6 months. Expenses related to pumping generally are much less (fathers tend to be interested in the cost savings.)
Breastfed infants tend to have fewer illnesses, resulting in less sick days for mom, lower medical costs for the family, and lower insurance costs for the employer.
Grandma is helpful as a caretaker but she (and many of her generation) do not understand the benefits of breastfeeding.

How can you help this mother overcome all of the hurdles, if she wants to? First, she needs role models: you may be one yourself! She may also benefit from talking with other moms who have done this….La Leche League may be helpful here. The lactation consultant should be able to review work-related nursing issues and direct her to her to get equipment, if necessary. Also, a lactation consultant may be able to talk to the employer regarding the cost effectiveness of breastfeeding in the workplace.

Regardless of what mom decides, if it involves a transition, she needs to start working on it now. Again, if she chooses to nurse or express at work, then she will need some extra support during the transition!

Quick Scenarios

- **Can I take acetaminophen/ibuprofen/aspirin while breastfeeding?** Yes
- **How long is pumped milk good out of the refrigerator?** Depends on the temperature
- **I get so thirsty when I nurse — is this normal?** Yes
- **At what age should my baby be back to birth weight?** By 2 weeks
- **When is a good time to introduce a bottle?** 4-6 weeks of age
- **I have a 101.5 temperature, and my baby is one week old — can I still nurse her?** Yes
  What else should I do? Consider seeing your health care provider if you have signs of mastitis/abscess.
- **My baby spits up about a teaspoon of milk a day. Is this ok?** Yes
- **Can I drink regular coffee?** Yes, up to 5 (5oz) cups per day or equivalent amt of caffeine (per LaLeche League International answer book)
- **Can I mix breastmilk with cereal?** Yes
- **When can my baby have yogurt?** 9-10 mo per AAP (over 6mo other resources)
- **When can my baby have whole milk?** After 1 year of age
- **When can my baby start using a cup?** As soon as he or she can manage it
- **Is it against the law to breastfeed in public?** No
- **My pumped milk has funny white stuff floating on the top. Is the milk spoiled?** No – this is milk fat.
- **Should I do Self Breast Exams while breastfeeding?** Yes
  When is the best time to do this? After a feeding/pumping — less milk in breasts makes for a better exam
- **How can I thaw frozen breast milk?** In refrigerator or in warm water - never microwave
- **What is diarrhea in a breastfed baby?** Increased frequency from normal (12-16 stools/day, watery/no substance, offensive odor)
- **Where can I rent a pump?**

The resources listed below do not in any way constitute Department of Defense endorsement of the private entity, its website, or its products.

Resources

1. *Breastfeeding: A Parent's Guide* – Amy Spangler
2. *The Nursing Mother's Companion* - Kathleen Huggins
3. *The Nursing Mother's Guide to Weaning* - Kathleen Huggins and Linda Ziedrich
4. *The Womanly Art of Breastfeeding* - La Leche League International
5. *Working Mother, Nursing Mother* - Gale Pryor
6. *Mothering Multiples* - Karen Gromada
7. *Breastfeeding Pure and Simple* - Gwen Gotsch
8. *So That's What They're For! Breastfeeding Basics* - Janet Tamaro
9. *The Breastfeeding Answer Book* - Nancy Mohrbacher and Julie Stock
10. http://www.cdc.gov/breastfeeding/NIS_data/index.htm
11. http://www.lalecheleague.org
12. International Lactation Consultant Association – Core curriculum for Lactation Consultant Practice (Marsha Walker, Editor)